

Prevention of Blood-Borne Infections

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Recommendations to Prevent Blood-Borne Infections Associated With Chemical Dependency

Executive Summary

Chemical dependency, particularly that involving the injection of drugs, continues to be a prevalent social problem, and is increasingly associated with the transmission of blood-borne and often life-threatening infections (e.g. human immunodeficiency virus [HIV], and hepatitis B and C virus, [HBV, HCV]). To reduce these public health impacts of chemical dependency among drug users, the Governor's Advisory Council on HIV/AIDS (GACHA) and the Governor's Council on Substance Abuse (GCOSA) formed a task force to identify problems and develop recommendations. The task force established three goals:

- To foster renewed and coordinated prevention efforts for chemical dependency and blood borne infections (BBI) among state agencies;
- To ensure that dependency is treated as soon as possible in every treatment-ready client; and
- To amend or rescind legislation and rules which impede these treatment and prevention efforts.

The need for such efforts is greatest among persons using or about to use illicit injectable drugs or by users of stimulant drugs either by injection or non-injection. There are an estimated 41,000 injection drug users (IDU) in Washington State, 70% of who are primarily addicted to heroin. Injection drug use directly or indirectly accounts for an increasing proportion (currently 21%) of the state's cumulative AIDS cases and more than one-third (36%) of cumulative cases nationwide.¹ HIV among injection drug users continues to be a growing problem, with as many as three-quarters of all new infections nationwide attributed to this group.²

The numbers of stimulant abusers are less well known, but there is an estimated 2-3,000 in King County who are also men who have sex with men (MSM). This subgroup has the highest rate of HIV infection (47%)³ of any group in the state due to combined risk factors of high-risk sex and drug injection.

Nearly all (85%) of the injection drug users in Seattle-King County are infected with HCV, most likely from continued needle sharing.⁴

The high cost of care for HIV and HCV as well as the devastating impact these diseases have on injection drug users, their families and society in general, and the great social costs of on-going drug abuse (including crime and incarceration) underscores the need to review the treatment, prevention, and law and justice barriers that impede or prohibit efforts to reduce the public health impacts of chemical dependency and blood-borne infections.

Blood-Borne Infections - Of major concern are HIV, HCV virus infection, and to a lesser extent HBV infection. While there are now treatments for AIDS and HIV that currently prolong and improve the quality of life, these treatments are expensive and require strict lifetime adherence. In the face of imperfect adherence, HIV mutates to drug-resistant forms which may be

retransmitted. The emergence of HIV resistance has recently been demonstrated in 16-26% of newly HIV-infected persons^{5,6} and is a problem that is expected to worsen over time.⁷

Treatments for HBV & HCV have not been universally effective or readily available. For example, treatment for HCV is only 40% effective at best⁸. Prevention of initial infection continues to be the best intervention for all these life-threatening illnesses.

Drug Treatment Issues - National research⁹ and local studies^{10,11} have consistently demonstrated that chemical dependency treatment is a highly cost-effective way to reduce the adverse health and social consequences of chemical dependency on individuals and society. To be effective, treatment services must be accessible geographically and financially. **The lack of locally available chemical dependency treatment services** with greatest effectiveness is a substantial barrier to recovery, since requiring clients to travel great distances at frequent intervals for treatment is both inefficient and costly. **The cost of treatment** is another substantial barrier, as many chemically dependent individuals have difficulty maintaining employment and do not have personal financial resources or insurance coverage.

Despite recent important revisions to the state's insurance regulations¹² which have greatly expanded coverage requirements for chemical dependency treatment, even individuals with health insurance may still have **limited coverage for chemical dependency treatment**. In addition, limits on the number, size, and location of programs, and restrictions on forms of treatment (e.g., methadone) that may be provided create significant barriers to treatment-ready clients. Inhibiting the use of illicit intravenous drugs through chemical dependency treatment is an important intervention in the prevention of blood-borne infections.

Chemical Dependency Prevention - Chemical dependency may be one of the most important problems in our society. The capacity of our prevention system to support sustained, targeted efforts to prevent initial use is limited by financial resources, lack of community acceptance, and limits on the number of available treatment slots. Planning and integration of all of the elements needed for a comprehensive approach to chemical dependency prevention is an even greater factor when resources are limited and often results in the exclusion of high-risk sub-populations.^{13,14,15} To be successful, the socioeconomic, cultural, educational and contextual elements of the environment, linked with the values and norms of the individual, peer group, family and community, must become an integral part of the prevention equation.^{16,17}

Prevention of Blood-Borne Infections - For those already addicted to drugs who cannot access effective treatment, effective strategies to prevent blood-borne infections must be fully implemented. Such strategies include outreach, education, and motivation of drug users, counseling & testing for blood-borne infections, and help in obtaining effective services.

The public health community and the state Supreme Court have concluded that needle exchange programs are effective and legally authorized preventative interventions. Many experts in public health, the medical community, pharmacy leaders, and legal scholars support access to equipment sold in pharmacies and the possession of equipment to prevent the spread of blood-borne infections.¹⁸

Law and Justice Issues - A variety of legislative and regulatory factors impede effective public health efforts to make sterile equipment more available. Many of these regulations represent well-intentioned efforts to prevent drug abuse; however, at the time that these laws were implemented, the public health impact of blood-borne infections was unknown. Thus, legislators could not have considered their public health ramifications. Several key legislative changes to these laws would dramatically improve and expand the public health efforts to prevent the reuse of contaminated hypodermic syringes and needles, as well as to increase access to drug treatment and other care services. Such changes should decrease the transmission of blood-borne infections.

RECOMMENDATIONS

The Joint Workgroup has developed the following recommendations for preventing the transmission of blood-borne infections among chemically-dependent individuals.

URGENT PRIORITY: We recommend immediate action on these items.

- **Allocate resources** to address the unmet need for chemical dependency treatment, particularly for persons who inject drugs or abuse stimulant drugs and those with blood-borne infections.
- **Amend the state's methadone treatment regulations** through the adoption of a bill similar to Senate Bill 5019 (1999) as a means of improving statewide access to opiate substitution treatment.
- Amend RCWs 70.115.050 and 69.50.4121 to **allow for the pharmaceutical sale and deregulation of clean syringes** for the prevention of blood-borne infections.
- **Support efforts by the State Board of Pharmacy** to allow pharmacists to voluntarily participate in blood-borne disease efforts.
- Allocate resources to **augment substance abuse prevention** efforts.
- **Oppose any congressional attempts to limit the ability of state or local public health officials to support needle exchange programs with state or local resources.**

IMPORTANT: We recommend action within the next year on these items.

- Direct Washington State government agencies to **coordinate existing advisory** groups to assure the consistency of prevention messages.
- **Direct and fund DSHS/DASA to undertake a statewide needs assessment survey** to determine gaps in comprehensive treatment for stimulant abusers at risk for blood-borne infections.
- **Direct and fund DOH to undertake a statewide needs assessment survey** to determine gaps in health care for blood-borne infections; prevention policies and programs; and access to substance abuse/dependency evaluation and referral.
- Amend RCW 69.50.412 to **allow for the limited possession of sterile syringes for legitimate public health purposes** to reduce the transmission of blood-borne infections.
- Support the collection of information and appropriate assessment measures regarding **adolescent risk behaviors leading to transmission of blood-borne infections.**
- **Support the establishment of more needle exchange programs** that provide an array of disease prevention services and utilize community oversight boards, including law enforcement representation.
- Direct DOH to work with care provider organizations to review and recommend procedures, as appropriate, to **get licensed healthcare providers to employ routine and careful screening for chemical dependency**, particularly among high-risk patients.

- Direct DSHS/DASA to work with care provider organizations to **identify and recommend solutions to communication barriers that interfere with coordinated patient care.**
- **Reaffirm the commitment of the State of Washington** to provide treatment and prevention support **for populations where blood-borne infections are most prevalent.**
- Integrate a skill building program statewide that **encourages state employees to become skilled at how to address judgmental attitudes** in their work environments and communities.
- **Encourage the universal integration** of blood-borne infection prevention into current substance abuse prevention programs and vice versa.
- **Assure that needle exchange staff are trained to refer to chemical dependency treatment** and that resources are available in the community to provide clients with comprehensive drug treatment services.
- **Continue the Corrections Outreach to Communities for Offenders with HIV/AIDS (COCOA) project with state funds** to strengthen the collaborations and communications among federal, state and local jail/prison systems and to improve the prevention and care of blood-borne illnesses in these settings.

I. Recommendations for the Prevention of Chemical Dependency and Transmission of Blood-Borne Infections

Problem

The prevention system is insufficient to prevent the initiation of substance use, which directly or indirectly leads to chemical dependency and behaviors which promote the transmission of blood-borne infections.

Discussion

Efforts to reduce or prevent people, especially children and teenagers, from becoming substance abusers has been a national focus since 1968. Chemical dependency prevention technology has evolved from scare and shock tactics to a more scientifically based, multi-disciplinary approach. Research projects, including longitudinal assessments and evaluations, by the National Institute of Drug Abuse, National Institute of Alcoholism and Alcohol Abuse, and the Centers for Disease Control and Prevention, have demonstrated that prevention efforts can be effective in a context of adequate dosage and maximum duration.

Chemical dependency does not happen overnight, or from one trigger, but results from a myriad of factors occurring throughout the developmental stage of a child's life. Research clearly shows that multiple systems must give consistent prevention messages to most effectively prevent chemical dependency.¹⁹ The duration of services, as well as the frequency and intensity of chemical dependency prevention programs, is all important to sustaining these preventative messages.

As a result of these studies and efforts, several ideas regarding chemical dependency prevention have become widely accepted by the treatment community. These include:

- It costs less to prevent initiation of alcohol, tobacco and drug use (primary prevention) than to stop use after addiction occurs;
- Primary prevention of drug abuse is also cheaper than the costs of its consequences, including treating subsequent blood-borne infections and/or incarceration;
- The initiation of alcohol and drug use results from complex decisions, influenced by a wide variety of personal and environmental factors;
- Any significant delay of the initial use of alcohol and other drugs is a positive outcome and may positively influence risk-taking behavior in other aspects of that person's life.^{20,16}

Recommendations

- *Augment state funding for the development, implementation and evaluation of prevention efforts prioritized to the highest risk populations, sub-populations or groups.*
- *Direct agencies of Washington State government to coordinate existing advisory groups for the following purposes:*
 - *To assure consistency of messages regarding prevention of substance abuse and the consequent transmission of blood-borne infections.*

- *To collaboratively support the development and maintenance of a comprehensive and sustained prevention model that impacts primary prevention of chemical dependency and its consequences.*

Problem

Data about adolescent health behaviors are incomplete and inadequate to best develop and target chemical dependency and blood-borne infection prevention programs. Also, threats exist to current data sources.

Background

Adolescents' health problems are often the result of preventable behaviors. Habits formed in adolescence can lead to diseases that do not manifest until adulthood.²¹ Empirical data about adolescents' health behaviors are needed at the state and local level to effectively target prevention efforts to reduce adverse outcomes.

Surveys of adolescent health behaviors must be representative of the population being studied - not biased by unnecessary constraints on survey methods. Anonymous and confidential self-report surveys by students at schools have been identified as a valid and reliable method of collecting health behavior data; however, schools which do not voluntarily participate create gaps in this important knowledge base.

Current Situation

In 1998, the fifth student survey measuring alcohol and drug use was conducted. The Washington State Survey of Adolescent Health Behaviours assesses the health-related attitudes and behaviors of Washington's students in public middle and high schools. The 1998 survey collected data on: intentional injury, including fighting and weapon carrying; alcohol, tobacco and other drug use; and risk and protective factors related to these adolescent health behaviors. Previous surveys have included information on other health issues, including sexual behavior, HIV, diet and suicide. The Youth Risk Behavior Survey conducted in 1999, also assessed alcohol, tobacco, and other drug use, fighting and weapon carrying, and other health-risk behaviors of adolescents.

Community controversy has influenced state agencies to eliminate survey questions on sexual behavior in this and other statewide surveys. Also, WAC 180-52-030 requires parental signature for surveys asking about sexual behavior.

Existing survey methods include random selection and voluntary participation of schools, and parental notification and opportunity to refuse student participation. In recent Washington State legislative sessions, bills (e.g., 1998 House Bill 2308) have been introduced to require active written consent from parents prior to administration of the survey. This change could bias survey results by restricting participation in the survey to those students with more involved parents, thus under-representing youth at higher behavioral risk. Survey administration costs would also increase significantly.

Recommendation

- *Direct state agencies to adopt policy positions that support the collection of confidential and anonymous information on adolescent health issues, including alcohol/drug use and sexual behaviors, in scientifically valid methods.*
- *Request revision of WAC 180-52-030 to allow passive parental consent (notification and opportunity to refuse) to improve our ability to measure risk factors for blood-borne infections among adolescents.*

Problem

There is a gap of effective education at both the community and individual level which addresses attitudes towards substance abuse, HIV disease, blood-borne infections and injection drug use.

Background

To reduce substance abuse and the spread of blood-borne infection, communities must recognize and support the need for treatment of individuals with chemical dependency and blood-borne infections. Through inclusive, and scientifically sound educational opportunities, it is essential to build trust and acceptance of substance abuse, HIV/AIDS, and other blood-borne infections as disorders that affect individuals, families, and communities like any other disease.

Current Situation

Washington State citizens need more education regarding the facts, fallacies, myths, and stigmas attached to the diseases of substance abuse, HIV/AIDS, and other blood-borne infections. The fear and shame often attached with these diseases must be replaced with compassion and understanding of these as medical conditions. Empathy for the impact of these diseases on individuals, their families, and on the entire community is essential to the prevention of blood-borne infections being transmitted through substance abuse. Apathy must be removed and judgmental attitudes resolved.

Prevention efforts must be designed and implemented to reduce judgmental attitudes while increasing the awareness of the connection of substance abuse and blood-borne infections.²² Planning must take advantage of the synergy that can result from the combined application of several efforts. Public leaders, together with public health officials and community coalitions, should increase cooperation and reduce the barriers that limit the effectiveness of community-based agencies' efforts.

Community settings in which these efforts must take place include schools, neighborhoods, workplaces, faith communities, treatment programs, and enforcement agencies.²³ Although several HIV and substance use prevention programs are operating in the state, few have been able to integrate prevention and treatment strategies. It is necessary to integrate alcohol, tobacco and other drugs, blood-borne infection prevention programs and substance use treatment to build a better continuum of care.

Recommendations

- *The Governor should lead the state of Washington in periodically reaffirming a commitment in support of the populations where blood-borne infections are most prevalent by publicly stating such a proclamation.*
- *DSHS/DASA should integrate a skill building program that encourages all state employees to become skilled at how to address judgmental attitudes in their work environments and communities.*
- *DSHS/DASA together with DOH should encourage the universal integration of Blood Borne Infections/Diseases prevention into existing substance abuse prevention programs and chemical dependency prevention into blood-borne prevention efforts.*

II. Recommendations to Improve Access to and Funding for Chemical Dependency Treatment

Problem

The lack of adequate treatment capacity, highly restrictive regulations on methadone treatment services, and inadequate information about and access to effective treatment for “stimulant drugs” (e.g., methamphetamine and cocaine), have led to competing treatment priorities and an uneven and inadequate distribution of services across the state.

Background

While not all drug users are ready for treatment at a particular point in time, state funding has never kept pace with the demand for chemical dependency treatment. While there may only be short waits before treatment is available for chemically dependent individuals who have adequate insurance or personal resources, Washington State government allocations provide treatment for only about 20% of low-income individuals in need of treatment.²⁴ Although this figure is based on a broader population than the injection drug use population, this estimate is conservative, and that the lack of treatment resources for injection drug users may be even worse.

Those at highest risk for blood-borne infections, injection drug users, generally have to wait many weeks or even months before drug treatment services can be obtained. In Seattle, for example, over 500 injection drug users are currently on a waiting list for opiate substitution treatment. The political will and state funding to provide the broad range of social support necessary to successfully modify and stabilize the often chaotic lifestyles of drug users in a consistent fashion has yet to be demonstrated. Furthermore, the social stigma frequently placed on chemical dependency and its treatment has limited the distribution and placement of treatment programs.

Methamphetamine (“crystal”) abuse appears to be an increasing problem statewide. These drugs promote prolonged and high-risk sexual activity among users, and some use this drug by injection, adding additional risk of blood-borne infection. On the West Coast, methamphetamine use is particularly prevalent among men who have sex with men (MSM).²⁵ MSM who use methamphetamines have the highest prevalence of HIV (47%) of any population in the state.³ Thus, methamphetamine abuse is likely the second leading drug-associated means of blood-borne infection transmission in our state. Additional study is necessary to fully understand the impact methamphetamine use is having on chemical dependency treatment centers, drug-related crime, fatalities, and HIV prevalence among at-risk populations.

Since access to chemical dependency treatment is severely limited, the public health goal to minimize the transmission of blood-borne infection indicates that services be prioritized for persons already carrying these infectious agents, as well as to persons at highest risk for acquiring and transmitting them. Without treatment, chemically dependent individuals with a blood-borne infection will continue their risk behaviors, resulting in further disease transmission. This will in turn adversely impact their own health, the health of their partners, and public health in general.

Current Situation

The economic costs of treatment for alcohol and other drug abuse in Washington State totaled \$160 million in 1996.²⁶ The majority of the treatment costs (58%) were paid by public funding, such as Medicaid and Medicare. Despite these public expenditures of more than \$93 million, only 21% of indigent Washington State residents needing treatment actually received it. According to the report, "the degree of unmet need for treatment when viewed in light of the economic cost of substance abuse raises compelling questions about the adequacy of Washington State's investment in treatment services".

Current figures estimate²⁷ that there are about 41,000 active injection drug users in Washington State, of which approximately 29,000 (70%) primarily inject opiates. Of these opiate abusers, only about 2,000 are enrolled in publicly funded opiate substitution treatment programs.²⁸ Due to restrictive state regulations, opiate substitution treatment is only available in four counties: King, Pierce, Spokane, and Yakima. Placement of approved programs is determined by local political processes and state law limits the enrollment in each program. Altogether, these programs are limited to serving 3,500 opiate dependents, 2,150 in King County and 1,400 persons in the other three counties. None of these state slots are prioritized for clients with HIV, hepatitis, or other blood-borne infections. (Clark County, meanwhile, provides funds to a neighboring Portland, Oregon treatment agency, but Clark County residents must commute to Oregon, often six days per week, for treatment.)

Without additional funding or changes in program caps, recovery for many opiate addicts is severely limited. In 1998, the city of Seattle had an all-time high in opiate overdose deaths, and showed the third highest rate of opiate positive urinalysis tests for male arrestees in the country.²⁹

The caps and licensing restrictions for methadone clinics limit the geographic distribution of such treatment centers. In 1999, chemically dependent persons testified before the State Legislature about the need to expand capacity and the locations of opiate substitution treatment programs and described having to travel many miles by car or bus in order to reach available services. Senate Bill 5019, introduced in the 1999 Legislative Session but left unconsidered by the representatives, would have greatly expanded the number of available methadone treatment slots, as well as relaxed the state's overly restrictive licensing requirements resulting in greater access to treatment.

Chemical dependency treatment agencies have helped people become aware of behaviors that increase their risk of getting blood-borne infection. Focusing on this risk helps attract substance abusers into treatment programs. Results for the US Center for Substance Abuse Treatment (CSAT) demonstration programs are being used as evidence that focusing on disease prevention can encourage reluctant substance abusers to seek and enter chemical dependency treatment. Now is a critical time to accurately assess and evaluate gaps in services to bridge prevention and treatment and to position the state for future funding opportunities.

Methamphetamine is a drug of particular concern given the recent significant increase in the manufacture and abuse of these drugs in Washington. Usage rates have been increasing at an alarming rate from the late 1980's to the present. Data compiled by the Department of Ecology and DSHS/DASA trace steep increases in the number of laboratory incidents and the rate of

treatment admissions for methamphetamine. Publicly funded treatment admissions for amphetamine use as the primary drug have increased 100 fold statewide between the fiscal years 1993 and 1999 (from 486 cases in 1993 to 4,864 in 1999).

Finally, in jail or prison settings, there are disproportionate numbers of inmates with crimes related to drug (including alcohol) use. The National Center on Addiction and Substance Abuse at Columbia University noted in their analysis of prison and jail inmate surveys³⁰ that 81% of state, 80% of federal and 77% of local jail inmates used an illegal drug regularly (at least weekly for a period of at least one month); had been incarcerated for drug selling or possession; had been driving under the influence of alcohol or another alcohol abuse violation; were under the influence of alcohol or drugs when they committed their crime; committed their offense to get money for drugs; had a history of alcohol abuse; or shared some combination of these characteristics.

In Washington State, the Corrections Outreach to Communities for Offenders with HIV/AIDS (COCOA) project is a collaboration between DOC and DOH. The COCOA project (whose current one-time funding is dependent on federal carry-over funds) is the result of an effort to improve access to HIV/AIDS treatments for persons incarcerated in state and local correctional facilities and to address transition issues to help assure continuity of care upon their release to the community. The project objectives are:

- Reducing the cost of HIV/AIDS care in correctional institutions.
- Improving continuity of care for HIV+ offenders during transition and release.
- Defining and sharing information on community resources for HIV concerns.
- Providing correctional staff information and continuing education to support their work with HIV+ inmates.
- Collecting and analyzing current HIV+ data within the correctional institution.

Given that screening for blood-borne infections among Washington State Department of Corrections inmates has shown a 1% prevalence of HIV infection^{31,32} and a 25% prevalence of HCV infection,³³ it is imperative that drug treatment programs in correctional settings address BBI prevention.

Even though there are 32 chemical dependency treatment programs in Washington State correctional settings, the opportunity to address the dual nature of disease and substance abuse by these programs needs to be expanded and enhanced. Screening at classification in Department of Corrections facilities has found that 80% of new prisoners have a chemical dependency problem.³⁴ This is also true in juvenile detention centers where the involvement with drug use is also high. It has been estimated that 82% of adolescents incarcerated in state juvenile correctional facilities are dependent upon or abuse alcohol, drugs or both.³⁵ Finally, the White House Office of Drug Control Policy has called for more drug treatment options in the criminal justice system, since Department of Justice statistics show that some 65% to 70% of untreated parolees who have used cocaine and heroin return to the drugs within three months of being released.³⁶

Recommendations

- *Persons with blood-borne infections, should be given a high priority for chemical dependency treatment “on-demand” to reduce chances of further spread of infection;*

- *Resources are needed to substantially increase capacity for chemical dependency treatment, targeting persons with limited or no insurance [and those within correctional settings].*
- *Due to the lack of adequate chemical dependency treatment capacity, the Governor's Council on Substance Abuse should be charged to work with DSHS/DASA to clearly identify priorities for chemical dependency treatment that include consideration of the societal/public health need to prevent the transmission of blood-borne infections.*
- *The Governor should strongly support the passage of a bill similar to Senate Bill 5019 (1999) as a means of improving statewide access to opiate substitution treatment. Senate Bill 5019 would have:*
 - *Removed treatment program size limitations;*
 - *Permitted DSHS/DASA to identify local jurisdictional opiate substitution treatment needs and to place treatment programs in those locations; and*
 - *Implemented a pilot program through which approved physicians could assume the methadone treatment management of stabilized clients.*
- *Direct and fund DSHS/DASA to undertake a state-wide needs assessment survey in collaboration with other public partners - to determine gaps in treatment for stimulant abusers, and whether specific chemical dependency treatment and prevention programs need to be added for these and other special populations.*
- *Direct and fund DOH to undertake a statewide needs assessment survey to determine gaps in blood-borne infection health care and prevention policies and procedures to assess for chemical dependency evaluation and referral.*
- *Continue the Corrections Outreach to Communities for Offenders with HIV/AIDS project with state funds to strengthen the collaborations and communications among federal, state and local jail/prison systems and to improve the prevention and care of blood-borne illnesses in these settings.*

Problem

Many care providers remain unaware of the increasing association between chemical dependency and blood-borne infections of the predictors of these conditions, and do not optimally screen their clients for them.

Background

While some providers are aware of the connection between chemical dependency and blood-borne infections, many others are reluctant to identify new and complex client problems that increase visit duration, often without commensurate increases in reimbursement. This problem is compounded by the increasing efforts to move people into managed care plans, and to further restrict reimbursement. Several studies demonstrate this lack of problem recognition in screening for HIV risk.³⁷

Opportunities for problem recognition – the first step towards problem correction – are too often missed, jeopardizing the health of these individuals and the public health in general. The extent of these gaps is unknown.

Current Situation

Chemical dependency is not evenly distributed in all segments of the population. It is well documented that drug dependencies are substantially more prevalent among incarcerated

persons³⁸ and those with mental illness.³⁹ More recently it has become clear that higher proportions of people at-risk for, or already infected with, HIV and other blood-borne infections are also chemically dependent.⁴⁰ As the HIV epidemic increases in socially disadvantaged and marginalized populations,⁴¹ these proportions appear to be growing. Additionally, the increasing prevalence of HCV, infecting four times as many people as HIV in the United States, is greatly associated with injection drug use.⁴²

Recommendation

- *The Governor should direct DOH, working with provider organizations, to review and find ways to improve screening for chemical dependency by licensed healthcare providers, especially among:*
 - *All persons at some risk of chemical dependency and blood-borne infection;*
 - *All persons being treated for mental illness; and*
 - *Persons in high-risk settings, such as at correctional facility intakes, at STD clinics, and at HIV and blood-borne infection counseling and testing sites.*

Problem

Effective treatment addressing patient needs and helping to keep chemical dependency patients in treatment is hampered by communication barriers between chemical dependency treatment providers and other health care providers (including primary medical care providers, mental health providers, and HIV/AIDS case-managers).

Background

Chemical dependency treatment programs policies may prohibit the use of certain drugs (e.g. benodiazapines, narcotics) while in treatment. Thus clients admitted to chemical dependency treatment may be required to discontinue needed medications resulting in exacerbations of psychiatric illnesses or lack of pain management, unless information from the primary physician is received regarding diagnoses and prescribed medications.

Linking chemical dependency treatment services to mental health and medical services is important in providing comprehensive services and for the retention of clients in all programs. Studies show that better outcomes result from coordinated services.⁴³ Effective communication between a client's providers at all levels is essential. Communication should occur routinely to (1) assure that necessary medications are not withheld while in chemical dependency treatment and (2) provide the patient with wrap around services which respects all providers and the client.

Upon admission to chemical dependency treatment, clients are surveyed about their medical and mental health history. Often times, clients choose not to disclose needed information, and chemical dependency staff are not aware of their medical or mental health diagnoses. In addition, current federal chemical dependency regulations place special protections on chemical dependency information, requiring special releases and authorizations for chemical dependency treatment information to be shared. Therefore, chemical dependency treatment staff may be unable to pursue communication with other providers for wrap around services without the client's consent.

Current Situation

Some clients compartmentalize their care, so that chemical dependency treatment staff are not aware of their medical or mental health backgrounds and vice versa. In addition, current federal chemical dependency regulations place special protections on chemical dependency information, requiring special releases and authorizations the order for chemical dependency treatment information to be shared. Therefore, chemical dependency treatment staff are often unable to or do not pursue these important communication connections or take the time to explain to clients the importance and potential benefits of coordinated care.

Recommendation

- *The Governor should direct DSHS/DASA to work with DOH and other care provider organizations (e.g., Washington State Medical Association) to identify and solve communication barriers that interfere with coordinated patient care.*

III. Recommendations to Ensure Access to Sterile Syringes

Problem

Access to sterile syringes is limited in Washington State, even in communities with needle exchange programs, due to state laws which prohibit the pharmaceutical sale of syringes, and paraphernalia laws that regulate their possession, distribution, and sale. The lack of access to sterile syringes continues to promote risk of transmitting blood-borne infections among continuing injection drug users.

Background

Ensuring access to clean syringes is the simplest means of reducing the spread of blood-borne infections among injection drug users. Current state law, RCW 70.115.050, prohibits a pharmacist from selling clean syringes unless he/she can “satisfy himself or herself that the device will be used for the legal use intended.”

Washington State is not alone in these restrictions: Ten other states place restrictions on the pharmaceutical sale of syringes, and eight states and one territory prohibit their sale without a prescription.⁴⁴ However, a growing number of states have recognized the negative public health impact of such restrictions and have begun to remove, or at least partially repeal, laws which impede access to clean syringes.

In 1992, the Connecticut State Legislature amended its prescription drug law to allow for the purchase of up to ten syringes without a prescription. This change helped reduce needle sharing among injection drug users by 40 percent; furthermore, the percent of injection drug users purchasing potentially contaminated needles on the black market decreased from 74% to 28%, and the percentage of injection drug users obtaining sterile syringes from a pharmacy increased almost 400% (from 19 to 78 percent).⁴⁵ At the same time, needle stick injuries to police officers declined three-fold.⁴⁶ Based on this success, other states, including Maine (1993), Minnesota (1997) and Massachusetts (proposed in 1999) have followed suit to improve legal access to clean syringes.

Connecticut, Maine, Minnesota, and Massachusetts (proposed) all limit pharmaceutical sales to ten or fewer syringes. Maine and Massachusetts limit sales to individuals of at least age 18. Minnesota and Massachusetts require pharmacies to provide on-site means for the safe disposal of used syringes, and provision of educational pamphlets for pharmacists (clarifying state law) and injection drug users (detailing the dangers of injection drug use, safe disposal techniques, and the availability of drug treatment services).

Pharmacies are the most common and simple means of accessing sterile syringes. However, Washington State law (RCWs 69.50.412 and 69.50.4121) prohibits the possession, sale, and distribution of drug paraphernalia which, according to RCW 69.50.102 includes “hypodermic syringes, needles, and other objects used, intended for use, or designed for use in parenterally injecting controlled substances into the human body.” Forty-seven other states and the District of Columbia have similar laws.⁴⁷ Washington, together with seven other states (HI, ME, MD, MA, NY, RI, VT) and DC, provides an exception in its paraphernalia laws for needle exchange

programs^{48,49} Some states, including Maine (1997) and Minnesota (1997), have gone further to ensure that all aspects of the public health effort to prevent blood-borne infections, including pharmacies, are exempted from existing drug paraphernalia restrictions.

Nationally, most drug paraphernalia laws were developed in response to the rapid increase in recreational drug use and the proliferation of the drug paraphernalia industry, beginning in the late 1960s. These laws were passed long before the beginning of the HIV/AIDS epidemic, and with little realization of, or regard for, the potential adverse public health impacts of these restrictions. With today's scientific knowledge regarding the transmission of blood-borne infections and the effectiveness of needle exchange programs, it is clear drug paraphernalia laws are a serious obstacle in the effort to ensure access to clean syringes for injection drug users. In fact, researchers at the St. Louis University School of Public Health found that states with neither drug paraphernalia laws restricting the possession of needles nor restrictions on the pharmaceutical sale of syringes have much lower AIDS rates than states with such restrictions.⁵⁰

State drug paraphernalia laws limit the role pharmacists can play in the public health effort to prevent the spread of blood-borne illnesses. Simply allowing for pharmaceutical sale does not address the additional roadblocks which possession laws place on injection drug users who seek to obtain, possess, and dispose of sterile syringes in order to reduce their risk for blood-borne infections. Although law enforcement officers rarely arrest individuals for simply possessing sterile needles, these statutes force injection drug users to avoid reliable suppliers such as pharmacists and to rely on black market sellers.

Current Situation

Support for improved pharmaceutical access to clean syringes is strong in Washington State. The Washington State Department of Health, the State Board of Pharmacy, the Governor's Advisory Council on HIV/AIDS, and AIDS service organizations across the state have advocated for changes to current state laws which impede pharmacists from assisting in public health efforts to prevent the spread of blood-borne infections.

In March 1999, the American Pharmaceutical Association encouraged all "state legislatures and boards of pharmacy to revise laws and regulations to permit the unrestricted sale or distribution of sterile syringes and needles by or with the knowledge of a pharmacist in an effort to decrease the transmission of blood-borne diseases."⁵¹ Recently, the Washington State Board of Pharmacy moved to adopt a definition of "legal use" for RCW 70.115.050 which includes "the distribution of sterile hypodermic syringes and needles for the purpose of reducing the transmission of blood-borne diseases."

Most pharmacists recognize the important role they play as part of the public health effort to prevent the spread of blood-borne infections. A recent survey of pharmacists in Louisiana found that a substantial majority (61%) had sold needles and syringes without prescriptions to customers they knew were not diabetics.⁵² However, many pharmacists reported a level of discomfort with this form of sale and the majority indicated they would be more likely to sell needles and syringes to injection drug users who were referred from an agency or clinic for that purpose.⁵³

Similarly, many injection drug users would prefer to purchase syringes over the counter rather than obtain them free of charge through needle exchange programs. In a 1990 study in Miami, 90% of injection drug users indicated approval of purchase, and 87% of these said they would

purchase syringes in this way if it were legal.⁵⁴ A 1994 study in Baltimore, Maryland found that if current legal restrictions were lifted, pharmacies would be a preferable means of access to clean syringes for many clients of needle exchange programs, particularly women. These studies indicate that pharmacies can play an important role in disease prevention,⁵⁵ particularly as the HIV epidemic expands among women and heterosexual men.

While needle exchange programs are not subject to drug paraphernalia laws under a decision by the Washington State Supreme Court,⁵⁶ pharmacists who sell clean syringes to injection drug users may face professional sanctions and criminal prosecution. This situation was further exacerbated by 1998 amendments to RCW 69.50.4121 which only *exempted* “public health and community based HIV prevention programs” from the statutes’ prohibition on the distribution of drug paraphernalia. Unless pharmacies are included in this exemption, they believe they must adhere to the strict prohibition on the sale or distribution of clean syringes and needles.

Experience in other states demonstrates the need for a combined effort to expand pharmaceutical access to syringes and repeal some drug paraphernalia laws in order to achieve the desired goal of reducing the transmission of blood-borne infections. In 1993, the Maine legislature removed restrictions on the pharmaceutical sale of clean syringes, but the state continued to have laws which made it illegal for a person to possess a syringe for the purpose of injecting illicit drugs.⁵⁷ This “Catch-22” confused both pharmacists and injection drug users, who could legally purchase syringes but then be arrested for carrying them. In 1997, Maine passed a bill that removed criminal penalties for the possession of ten or fewer syringes.⁵⁸ The bill had the support of public health officials, law enforcement and community-based organizations.

Other states have learned from the example of Maine, and have revised their pharmacy sale and drug paraphernalia laws simultaneously. The Minnesota Legislature went so far as to remove needles from the state’s list of restricted drug paraphernalia when they are sold through a pharmacy in quantities of 10 or fewer. Connecticut provides a similar dispensation and proposed legislation in Massachusetts would do the same. In order to limit access to sterile syringes, Connecticut and Minnesota require that pharmacies keep them behind the counter, rather than placing them on the sales floor. A growing number of states recognize that by permitting injection drug users to legally purchase and possess a limited number of hypodermic syringes and needles, it is easier to ensure that injection drug users comply with the public health advice to use a new syringe for each injection.

Access to sterile syringes has become a highly politicized issue amongst those most removed from the front-line of disease prevention efforts. Despite the clear disease prevention benefits associated with needle exchange, many members of Congress equate these programs with a defeat in the war on drugs. Although no federal dollars are currently spent to support needle exchange programs, local public health jurisdictions and HIV/AIDS prevention agencies across the country support more than 150 exchange programs. Washington State has been at the forefront of this effort. In the past few years, Congress has attempted to pass legislation or include policy riders on appropriations bills that would prohibit even local public health jurisdictions from operating needle exchange if they received any federal funding. Such legislation disagrees with the ideals of local control, would jeopardize the existence of the needle exchanges currently operating in Washington State, and disagrees with accepted scientific evidence.

Recommendations

- *Amend RCW 70.115.050 and 69.50.4121 to allow for the pharmaceutical sale of sterile syringes.*
 - *Sales should be limited to ten syringes.*
 - *Sales should be limited to individuals at least eighteen years old.*
 - *Pharmacists should be required to provide drug prevention and treatment materials at the point of sale.*
- *The Governor should strongly support efforts by the State Board of Pharmacy to allow pharmacists to voluntarily participate in disease prevention efforts.*
- *Amend RCW 69.50.421 to allow for the limited possession and sale of sterile syringes for legitimate public health purposes.*
- *Oppose any congressional attempts to limit the ability of state or local public health officials to operate or support needle exchange programs.*

Problem

Needle exchange programs are limited in their capacity to meet client needs for the prevention of blood-borne infections.

Background

Many chemically dependent individuals have a wide variety of often-urgent medical, situational and emotional needs in addition to their chemical dependency. Many of them have limited options for obtaining help to address these issues due to their addiction, concurrent mental or physical health problems, and lack of insurance and/or personal resources. In addition, many chemically dependent persons are homeless.⁵⁹ Programs serving chemically dependent persons should be responsive to the clients' multiple health care needs and must be prepared to assist these individuals with problem-focused interventions either directly or through specific referrals. In particular, because needle exchange programs provide access to clients that are often not reached through other public health venues, needle exchange programs must be able to provide an array of disease prevention services, not just one-for-one exchange of sterile for contaminated injection equipment.

Comprehensive services at needle exchange sites should include services such as: education about HIV and other blood-borne infections; provision of clean paraphernalia (including sterile syringes, alcohol swabs, clean cotton, bleach, etc.) and condoms; referral to drug treatment and medical care; on-site HIV and hepatitis counseling and testing, or at minimum referral to such services; vaccination or referral for vaccination for hepatitis; and assistance and advice about housing or other needed social services.^{60,61}

The processes whereby such programs are considered, implemented and maintained should be initiated or overseen by local public jurisdictions and include law enforcement leaders, community and governmental leaders, and drug treatment agency representatives. Community and law enforcement support of these programs hinges on the capacity of the needle exchange program to provide a wide array of disease prevention services.

Current Situation

In Washington State, needle exchange programs are operational in the following counties: Spokane, Walla Walla, Yakima, Whatcom, Island, Skagit, Snohomish, King, Pierce, Thurston, Clark and Skamania. In addition, the “Prevention Plus Program” (linking Regions I & II) is in the process of setting up a mobile syringe exchange in other counties. While all programs provide educational materials and referrals, some programs do not have sufficient resources to provide on-site services (e.g., HIV counseling and testing) or provide follow-up to assure that referrals were completed.

Some persons, including local law enforcement staff, will continue to have concerns about needle exchange programs. Therefore, law enforcement officials must have opportunities to continue to be involved in decisions about these programs and be educated about the array of disease prevention services provided.

Recommendations

- *Needle exchange sites serving chemically dependent individuals must be properly trained and able to provide clients with assistance (on-site when feasible or through referral when necessary) to a broad array of frequently needed services, including drug detoxification, chemical dependency treatment, case management, medical care, and other social support services. Additional resources maybe needed to enable programs to develop and maintain appropriate service models and to adequately train and support staff to provide these services.*
- *Representatives from law enforcement public health, chemical dependency treatment and prevention and other interested persons need to be involved in the establishment, implementation, and maintenance of needle exchange programs.*

Appendix A: The Role of Needle Exchange in the Prevention of Blood-Borne Infections

The transmission of blood-borne infections, including HIV, is largely the result of two major risk behaviors: unprotected sex with exposure to infected semen or vaginal/cervical fluids, and parenteral exposure to infected blood (mostly through shared needles). The risk of transmission of blood-borne infection through injection drug use remains high, supporting the continued need for non-shared, sterile syringe use by injection drug users

Many of the most effective means of reducing the transmission of blood-borne infections have become highly politicized issues, particularly needle exchange programs and the placement of drug treatment programs. Despite the politics at play, the need for prevention and treatment is great and the scientific evidence is clear: clean needles help to prevent the spread of disease and do not encourage drug use.⁶²

Background

As of July 1999 it is estimated that there are over 150 needle exchange programs operating in 39 states.⁶³ Needle exchange programs arose in the latter part of the 1980s in the Netherlands in response to the spread of hepatitis B virus infection among injection drug users. Early AIDS data that indicated that injecting drug users were transmitting HIV via non-sterile syringes and needles argued for similar programs to prevent the spread of disease.

Needle exchange in Washington State was initiated in Tacoma in August 1988 and currently operates in eleven counties. Needle exchange was challenged legally by the Pierce County Prosecuting Attorney in 1989. The 1990 ruling in that instance supported the exchange of syringes. As additional communities across the state adopted syringe exchanges, a second legal challenge by the Spokane County Prosecuting Attorney occurred in 1992. In that case the Washington State Supreme Court upheld the earlier Pierce County ruling solidifying syringe exchange as a legal public health intervention as “within the prerogative of the local health officer as a public health intervention.”⁶⁴

The Supreme Court ruling, however, left in its wake a conflict with existing law, specifically RCW 70.115.050 which states in part that “the retailer shall satisfy himself or herself that the device (i.e., a syringe, needle or other device used for injecting drugs) will be used for the legal use intended.” The code (RCW 69.50.4121) further states, “Every person who sells or gives, or permits to be sold or given to any person any drug paraphernalia in any form commits a class I civil infraction under 7.80 RCW.” These sections consequently create a conflict for selling or distributing syringes outside an authorized needle exchange program.

Discussion

Conflict between pre-existing paraphernalia laws and the State Supreme Court’s needle exchange decision have resulted in confusion and interpretative differences between public health officials, pharmacists, law enforcement and community-based organizations. Some of these concerns have led local governing health boards, most often composed of citizens and elected officials, to differ in their interpretation of either the cost-benefit or potential legal

ramifications of permitting needle exchange programs to operate within their jurisdictions. Similar concerns have been raised by pharmacists. The current contradiction between case law supporting needle exchange and statutory law restricting the sale of syringes leaves them in a potentially vulnerable position. They are not covered in the scope of the Supreme Court ruling empowering local health officials to conduct needle exchange. Yet, they remain on the front lines of the epidemic as injection drug users seek to purchase sterile syringes from them in retail settings.

Regardless of the legal interpretation or the resource issues involved, there are multiple pros and cons that have been used to support or oppose needle exchange programs, or the pharmaceutical sale of such equipment, as viable public health interventions. The majority of those arguments can be lumped into several categories: the promotion of drug use, the bridge to treatment, conflicting evidence on whether needle exchange programs do anything to contain the spread of disease, and concerns that needle exchange programs send mixed messages to youth. A brief discussion of each of these points follows but is by no means an exhaustive representation of the substantial body of literature that has arisen around needle exchange programs.

The promotion of drug use - A report by the National Institutes of Health (NIH) concluded that needle exchange programs “show a reduction in risk behaviors as high as 80 percent in injecting drug users, with statements of a 30 percent or greater reduction of HIV.” In addition, the panel concluded that the preponderance of evidence “shows either a decrease in injection drug use among participants or no changes in their current levels of drug use”.⁶⁵

Decrease of sharing - While many needle exchange programs have recorded information about the decrease of equipment sharing, a 1998 article in the *American Journal of Public Health* noted that rates of HIV in injection drug users in Hawaii dropped from 5% in 1989 to 1.1% in 1994-96, a drop attributed to a 74% decrease in needle sharing among needle exchange clients.⁶⁶ Most evaluative studies of needle exchange programs, including a recent study conducted in Seattle, indicate a reduction of needle-sharing among program participants.⁶⁷

Bridge to Treatment - Needle exchange programs are often associated with, or provide referrals to, drug treatment programs. In Washington, needle exchange programs are an important source of referral to drug treatment in the state. In 1998 for instance, the Spokane Needle Exchange Program referred 214 clients to drug treatment. Most programs at least offer information about treatment options, but some even provide clients with vouchers that provide immediate program access in some cases. A lack of available treatment slots, particularly for methadone treatment for opiate users, is a major impediment to successfully breaking the cycle of drug abuse.

Needle Exchange Programs as protection against Blood-Borne Infections - There have been mixed reports as to the effect of needle exchange programs on the reduction of blood-borne infections in injections drug users. Two Canadian studies (one in Montreal in 1996⁶⁸ and another in Vancouver in 1997⁶⁹) found that needle exchange program participants were more likely to be exposed to HIV than those injection drug users who did not participate in a needle exchange program.

These findings are different from the experience at the Seattle-King County needle exchange program, where the rate of HIV transmission among injection drug users has remained low and fairly stable. However, the incidence of hepatitis B and C remains at 10% and 21% annually among needle exchange program participants.⁴ The prevalence of hepatitis B and C in this same study was nearly 70% for hepatitis B and 80-90% for hepatitis C. Further studies are needed to determine why hepatitis seems to be transmitted much more readily than HIV in this population and better hepatitis prevention programs need to be developed for injection drug users.

The mixed “message” - Since the introduction of needle exchange programs, there have been on-going concerns that they send a “mixed” message about drug use. There is the possibility that by supplying injection drug equipment, needle exchange programs undermine the nation’s “War on Drugs” effort. While the focus of this paper is not to explore the ramifications of either position, a recent study in Baltimore found that the presence of a needle exchange program near a school was not likely to encourage students to begin injecting drugs.⁷⁰ Several other studies have reported that injection drug users reduce or maintain their rate of injection while participating in exchange programs.^{71,72,73}

Regardless of any of these concerns, there remains an overarching public health need to reduce the transmission of blood-borne infections that are transmitted through the use of contaminated injection equipment. The cost-benefit of this approach has been addressed in various studies and the US Centers for Disease Control and Prevention has estimated that preventing a single case of HIV saves more than \$150,000 in HIV/AIDS-related medical care.

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